TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Ennis, Gregory Philip

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-16-3135-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
June 14, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review the entire narrative report to find the elements required for ROS, PFSH and HPI. In addition please review the exam score sheet attached demonstrating that an exam was performed meeting the level of service billed herein. This of course would meet the requirements of two of the three components of documentation required for subsequent visits."

Amount in Dispute: $186.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester billed code 99214. Texas Mutual denied payment because the requestor's documentation does not meet the CPT criteria for 99214. The History is expanded problem focused, the Examination is detailed, and the Medical Decision making is straightforward."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 14, 2016	99214, 99080 -73	$186.25	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

3. 28 Texas Administrative Code §129.5 sets out the guidelines for work status reports.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 150 – Payer deems the information submitted does not support this level of service
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
   - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information
   - 248 – DW-73 in excess of the filing requirements; no change in work status and/or restrictions; reimbursed denied per Rule 129.5
   - 193 – Original payment decision is being maintained upon review, it was determined that this claim was processed properly

Issues

1. The insurance carrier denied disputed service 99214 with claim adjustment reason code 150 – "Payer deems the information submitted does not support this level of service." 28 Texas Administrative Code §134.203(b) states in pertinent part,

> For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
>
> (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

The submitted code in dispute has a narrative description of 99214 – Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

Review of the submitted document titled, "Follow Up Patient Visit" finds:

Required Element	Present within Submitted Documentation Findings	Requirement of Code Met
Detailed History	History of present illness – (1) condition Review of systems – Complete Past medical, family, social history – Complete Score – Expanded Problem Focused	No
Detailed Examination	Body areas – Each Extremity (1) Organ Systems – 5 Score – Expanded Problem Focused	No
Medical decision making of moderate complexity	Number of Diagnoses or Treatment Options – (1) Elemental Level: Minimal Amount and /or Complexity of Data Reviewed – (none)	No

Usually, the presenting problem(s) are of moderate to high severity	Risk of Significant Complications, Morbidity, and / or Mortality Level of Decision Making: Low Complexity	None
Typically, 25 minutes are spent face-to-face with the patient and/or family	"The patient spent a total of 108 minutes in the center, with more than a minimum of 25 minutes of that time being face to face with medical staff and providers	Yes

Based on the above, the carrier's denial is supported as two of the three required components were not met.

2. The carrier denied code 99080 – Special reports or forms as 248 – "DWC-73 in excess of the filing requirements; no change in work status and/or restrictions; reimbursed denied per Rule 129.5." 28 Texas Administrative Code §129.5 (d) states in pertinent part,

   The doctor shall file the Work Status Report:

   (1) after the initial examination of the employee, regardless of the employee's work status;

   (2) when the employee experiences a change in work status or a substantial change in activity restrictions; and

   (3) on the schedule requested by the insurance carrier (carrier), its agent, or the employer requesting the report through its carrier, which shall not to exceed one report every two weeks and which shall be based upon the doctor's scheduled appointments with the employee.

   Comparison of the reports from February 18, 2016 and December 31, 2015 found no change in work status or a substantial change in activity restrictions nor was supporting evidence of a request by the carrier found. The carrier's denial is supported.

3. Pursuant to the above, no additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		August 11, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.